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ABSTRACT

This monograph offers an introduction to providing an interagency "system of care" for meeting the needs of children and youth with emotional/behavioral disorders (E/BD). This approach focuses on meeting the individual needs of children with E/BD in their home communities and supporting family members as allies in the treatment process. Strategies such as wrap-around services, intensive family intervention, crisis intervention, day treatment programs, therapeutic foster care, respite care, and coordinated planning are often included in a system of care. After an introductory chapter, the guide: (1) provides a rationale for a system of care based on E/BD individuals' complexity of needs, current poor outcomes, and high costs and failure of current services; (2) traces the development of three models of service delivery: the system-of-care approach, the evolution of that approach into individualized strategies, and application of system-of-care principles to school-based services; (3) explores important components in providing individualized services including interagency collaboration, goals and commitment, case management, flexible funding, family-based planning, and evaluation; and (4) describes key strategies and considerations for developing a system of care in a local district, suggesting that barriers to interagency collaboration can be overcome by a strong child services coordinator and an interagency planning process that focuses on the needs of children and families. (Contains 88 references.) (DB)

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From the Mini-Library Series on Emotional/Behavioral Disorders

Developing a System of Care: Interagency Collaboration for Students with Emotional/ Behavioral Disorders

Russell Skiba

Lewis Polsgrove

Karen Nasstrom

Indiana University

Council for Children with Behavioral Disorders

Published by
The Council for Children with Behavioral Disorders

1996

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About the Council for Children with Behavioral Disorders

CCBD is an international professional organization committed to promoting and facilitating the education and general welfare of children/youth with behavioral and emotional disorders. CCBD, whose members include educators, parents, mental health personnel, and a variety of other professionals, actively pursues quality educational services and program alternatives for persons with behavioral disorders, advocates for the needs of such children and youth, emphasizes research and professional growth as vehicles for better understanding behavioral disorders, and provides professional support for persons who are involved with and serve children and youth with behavioral disorders.

In advocating for the professionals in the field of behavioral disorders, CCBD (a division of The Council for Exceptional Children) endorses the Standards for Professional Practice and Code of Ethics adopted by the Delegate Assembly of The Council for Exceptional Children in 1983.

About This Monograph

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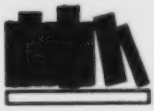

About the Mini-Library Series on Emotional/Behavioral Disorders

Foreword

Today, professionals are struggling to discover ways to deal successfully with a heterogeneous population of students, some of whom are especially difficult to manage and instruct. No other group of youngsters poses a greater challenge than those variously labelled "seriously emotionally disturbed," "behaviorally disordered," or "emotionally/behaviorally disordered." These children and youth manifest a combination of social, academic, and behavior problems that require not only powerful individual strategies but also effective program options. Fortunately, there is a growing body of knowledge regarding what constitutes quality practices for students with emotional/behavioral disorders (E/BD).

This mini-library series targets the most crucial issues and concerns regarding these children and youth. It covers the needs of students of various ages who are being served in different programs and settings and who demand diverse policy considerations. The mini-library derives from the 1995 international conference sponsored by the Council for Children with Behavioral Disorders. The seven monographs and their authors are

- *Best Practices for Managing the Behavior of Adolescents with Emotional/Behavioral Disorders Within the School Environment*
  Beverley H. Johns, Eleanor C. Guetzloe, Mitchell Yell, Brenda Scheuermann, Jo Webber, Valerie G. Carr, and Carl R. Smith
- *Developing a System of Care: Interagency Collaboration for Students with Emotional/Behavioral Disorders*
  Russell J. Skiba, Lewis Polsgrove, and Karen Nasstrom
- *Early Intervention for Young Children At Risk for Emotional/Behavioral Disorders: Implications for Policy and Practice*
  Wesley Brown, Maureen A. Conroy, James J. Fox, Joseph Wehby, Carol Davis, and Mary McEvoy
- *Effective Strategies for Teaching Appropriate Behaviors to Children With Emotional/Behavioral Disorders*
  Robert B. Rutherford, Jr., Mary M. Quinn, and Sarup R. Mathur

- *Planning and Implementing Effective Programs for School-Aged Children and Youth with Emotional/Behavioral Disorders Within Inclusive Schools*
  Howard S. Muscott, Daniel P. Morgan, and Nancy B. Meadows
- *Teacher-Mediated Behavior Management Strategies for Children With Emotional/Behavioral Disorders*
  Sarup R. Mathur, Mary M. Quinn, Robert B. Rutherford, Jr.
- *Types of Youth Aggression and Violence and Implications for Prevention and Treatment*
  Richard Van Acker

As editors, we strove to bring together information with practical value to the teachers, administrators, and other professionals who must respond to the challenges posed by children and youth with E/BD. We hope this mini-library series will contribute to your success and the success of the students with whom you work.

Lyndal M. Bullock
University of North Texas

Robert A. Gable
Old Dominion University

Series Editors

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Introduction

The theme of this series on children and youth with emotional/behavioral disorders (E/BD) is *success*. Nevertheless, there is growing realization in the field of children's social services that the current system of services often is unsuccessful in meeting the needs of children and their families (Grosenick, George, & George, 1987; Knitzer, Steinberg, & Fleisch, 1990; Neel, Meadows, Levine, & Edgar, 1988)

The mounting flood of violence and antisocial behavior in today's schools is commanding an increasing share of attention (Soriano, Soriano, & Jimenez, 1994). More children are becoming victims of the cycle of unemployment, poverty, homelessness, and despair; neglect, malnutrition, and abuse are becoming commonplace (Gorski & Pilotto, 1993). Barriers to successfully treating these conditions can be found in the escalating costs of inpatient and residential services, foster care, therapy, and counseling programs; adherence to inflexible, inefficient policies; lack of funding; and the spiraling demands for services (Knitzer & Yelton, 1990). In the face of such barriers, even the most potent educational and behavioral interventions often fall short.

In response to these conditions, social service practitioners have begun to explore more effective services models, stressing collaboration, pooled resources, and coordinated assistance. Increased attention to collaborative service is apparent in such diverse fields as early childhood special education (Peterson, 1991), vocational rehabilitation (Greenan, 1986), mental health and child welfare (Knitzer & Yelton, 1990), and services for at-risk students (Guthrie & Guthrie, 1991).

Recently, professionals have begun to realize the necessity of integrating social services into what Stroul and Friedman (1986) identified as a *system of care*. This approach focuses on meeting the individual needs of children with E/BD in their home communities and supporting family members as allies in the treatment process. Strategies such as wraparound services, intensive family intervention, crisis intervention, day

treatment programs, therapeutic foster care, respite care, and coordinated planning offer new and dynamic alternatives to address the complex problems of children with E/BD and their families (Burchard & Clarke, 1990; Knitzer & Yelton, 1990).

This monograph offers an introduction for educators to this important new approach. We will describe the rationale and need for a system of care and outline the components of model programs. Most importantly, we hope to offer concrete strategies that can provide guidance to school districts interested in developing local systems of care for students with E/BD.

The Need for a System of Care

2

The difficulty in providing services to students and families with complex problems has led to the consideration of interagency approaches.

Increasingly, educators of children with emotional/behavioral disorders (E/BD) are realizing that special education alone cannot solve the problems of these children and their families. A number of factors point to the need for new approaches to service delivery.

1. Complexity of Needs

The origins of E/BD are complex, and so are the ways in which they are expressed. Students exhibiting E/BD often are exposed to a variety of stress factors including community violence (Garbarino, Kostelny, & Dubrow, 1991), family discord (Emery, 1988), inconsistent and inadequate discipline and monitoring (Reid & Patterson, 1991), and parents who themselves have mental health difficulties (Wahler, 1980). As a result, these children and youth exhibit a broad range of coexisting emotional and behavioral difficulties (McConaughy & Skiba, 1993).

No single approach seems capable of meeting such complex needs. Behavioral approaches, such as token economies and level systems, that show tremendous promise in the research literature (Nelson & Rutherford, 1988) often seem ineffective in practice (Knitzer, Steinberg, & Fleisch, 1990). The most well-researched practices are often the result of carefully controlled conditions; carefully controlled conditions,

however, do not characterize the lives of children with conduct and emotional problems.

2. Outcomes

One of the more troubling statistics concerning students with E/BD is their poor prognosis for success. Irrespective of treatment strategy, follow-up studies of such children and youth have shown a continuing high incidence of aggression and antisocial behavior (Faretra, 1981), reinstitutionalization (Bloom & Hopewell, 1982), and a high risk for ongoing psychopathology (Kazdin, 1987). According to the *13th Annual Report to Congress*, students with E/BD have the lowest graduation rate (30.7%) and the highest dropout rate (39%) of any disability area (U.S. Department of Education, 1991).

3. Cost of Current Services

Despite a general movement in the field of special education toward integration in less restrictive settings, available data suggest that students with E/BD are significantly overrepresented in the most restrictive continuum placements, particularly residential care (Kauffman & Lloyd, 1992). Service in the most restrictive settings is simply not cost-effective: Costs for out-of state placements are typically estimated as costing $90,000 or more per month (Dowrick, 1988; Epstein et al., 1993).

4. Failure of Current Services

The problem of children "falling through the cracks" of the social service system is, unfortunately, a too-often told story. It is ironic that professionals' best intentions as individual service providers—to help children and their families—often seem thwarted by the very systems put in place to serve those children and families. Conflicting eligibility requirements, insufficient resources, and a maze of regulations and requirements all make it difficult for families to access needed services.

Knitzer (1982) documented these failures in her book *Unclaimed Children*. Commissioned by the Children's Defense Fund, this study found that two out of three children who were seriously disturbed and their family received no services. Parents reported receiving little assistance in finding services and experienced little support for using services in the community. The report suggested both strengthening the services and links between those services and increasing effective advocacy for seriously disturbed children.

Coordinating Care: Individualized Services in the Community and School

3

System-of-care and wraparound approaches have been successful in the community and are beginning to be applied in the schools

In response to the concerns enumerated in Chapter 2, new models of service delivery have been proposed and piloted extensively in the last decade. In this section, we trace the development of three such approaches: the system-of-care approach (Stroul & Friedman, 1986); the evolution of that approach into individualized care, using strategies such as wraparound services; and finally, several programs that have applied those principles to school-based services.

• The CASSP System-of-Care Model

In direct response to concerns identified by Knitzer (1982) and others, the National Institutes of Mental Health launched the Children and Adolescent Service System Program (CASSP) in 1984. Charged with assisting states and communities in developing comprehensive systems of care for students with emotional disturbance, CASSP has, in its first 10 years, involved programs from all 50 states. In contrast to current fragmented approaches for service delivery, the system of care represents

> A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families. (Stroul & Friedman, 1986, p. 3)

This concept recognizes that children with emotional/behavioral disorders (E/BD) and their families have complex and multiple needs that cannot be met by any single agency. Rather, multiple services that cut across agency boundaries and are coordinated into a network of support are necessary.

Central to the system-of-care idea is a philosophy of service emphasizing a set of core values and principles (Stroul & Friedman, 1986). These are reprinted in Table 1. The first important value stresses that the system of care must be *child centered and family focused*. This value describes a commitment that "enhances the personal dignity of children and families, respects their wishes and individual goals, and maximizes opportunities for involvement and self-determination in the planning and delivery of services" (Stroul & Friedman, 1986, p. 16). Second, services must be *community based*. Current models in both mental health (Behar, 1985) and education (Knitzer, 1993) demonstrate an overreliance on more restrictive, out-of-community placements for children with more severe disorders. As noted, such models are neither cost-effective nor humane. Third, systems of care must be *culturally competent*. Cross, Bazron, Dennis, and Isaacs (1989) define cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (p. 13).

In the 10 years since the CASSP initiative was launched, model programs have sprung up around the country. Among the most widely cited of these is the Ventura Planning Model (Jordan & Hernandez, 1990). That model is based on the premise that "a community-based, interagency system of mental health care that targets the most disturbed children will provide the greatest benefit to children, their families, and the community at the lowest cost to the public sector" (Goldman, 1992, p. 292). The Ventura Planning Model defines five elements in its system of care:

- A clearly defined target population.
- Measurable goals based on the preservation of family unity and local treatment.
- Interagency coalitions.
- Services and standards that adhere to program goals.
- Systems evaluation.

Jordan and Hernandez (1990) document a number of impressive outcomes for the model: out-of-state hospitalization dropped by 68%; group-home placement costs were reduced by $410,775, while placements in

TABLE 1
Values and Principles for the System of Care

Core Values

1. The system of care should be child centered and family focused, with the needs of the child and family dictating the types and mix of services provided.
2. The system of care should be community based, with the locus of services as well as management and decision making responsibility resting at the community level.
3. The system of care should be culturally competent, with agencies, programs, and services that are responsive to the cultural, racial, and ethnic differences of the populations they serve.

Guiding Principles

1. Children with emotional disturbances should have access to a comprehensive array of services that address the child's physical, emotional, social, and educational needs.
2. Children with emotional disturbances should receive individualized services in accordance with the unique needs and potentials of each child and guided by an individualized service plan.
3. Children with emotional disturbances should receive services within the least restrictive, most normative environment that is clinically appropriate.
4. The families and surrogate families of children with emotional disturbances should be full participants in all aspects of the planning and delivery of services.
5. Children with emotional disturbances should receive services that are integrated, with linkages between child-serving agencies and programs and mechanisms for planning, developing, and coordinating services.
6. Children with emotional disturbances should be provided with case management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that they can move through the system of services in accordance with their changing needs.
7. Early identification and intervention for children with emotional disturbances should be promoted by the system of care in order to enhance the likelihood of positive outcomes.
8. Children with emotional disturbances should be ensured smooth transitions to the adult service system as they reach maturity.
9. The rights of children with emotional disturbance should be protected, and effective advocacy efforts for children and youth with emotional disturbances should be promoted.
10. Children with emotional disturbance should receive services without regard to race, religion, national origin, sex, physical disability, or other characteristics, and services should be sensitive and responsive to cultural differences and special needs.

Note. From *A system of care for children and youth with severe emotional disturbances* (p. 18) byB.A. Stroul & R. M.Friedman, 1986. Washington, D. C.: Georgetown University Child Development Center, CASSP Technical Assistance Center. Copyright 1986 by IDK. Reprinted with permission

group homes dropped from more than 130 to between 80 and 90 per month; and a reduction of 17.9% in non-public-school placements. Stroul (1993) has documented a host of other impressive outcomes for system-of-care approaches, including improvements in behavioral and academic functioning, decreased involvement with juvenile justice and corrections, and increased parent satisfaction with services.

• Individualized Care and Wraparound Services

Some communities and programs have taken the system-of-care framework a step further, radically changing the way services are delivered. Dubbed "individualized care" (Burchard & Clarke, 1990; Katz-Leavy, Lourie, Stroul, & Zeigler-Dendy, 1992), this approach grew out of innovative programs such as the Alaska Youth Initiative (VanDenBerg, 1989), the Kaleidoscope Program in Chicago (Dennis & Porter, 1993), and Project Wraparound in Vermont (Burchard, 1995). In addition to the principles and interagency coordination just described, individualized care emphasizes the concept of *wraparound services* and the several features needed to make wraparound possible.

The notion of wraparound services was first described by Behar (1985). Rather than expending local and state resources on expensive residential placements, communities can expend those resources on local services, which are "wrapped around" the child and family in an effort to successfully maintain the child in the local community. Burchard and Clarke (1990) contrast the wraparound approach with what they term *component care*. While component care services are restricted in location, wraparound services can be delivered in any location, at any time. While component care services are limited to professionals within a specific setting, wraparound services are tailored to an individual's needs and may be delivered by friends, family, or community members.

Several features have been identified as important in making individualized wraparound services work. The first is *flexible funding*; money that would otherwise be spent on out-of-state residential treatment or on categorical services is used flexibly to support a variety of community services. The second important feature is *case management*; identified as a key feature in individualized services (Burns & Friedman, 1990), the case manager pulls needed services together by acting as an advocate for individual students with E/BD and their families. Finally, successful wraparound programs rely on the value of *unconditional care*; that is, programs using an individualized services approach make a commit-

ment to serving children, regardless of the severity of their behavior. Each of these values will be described in greater detail in Chapter 4.

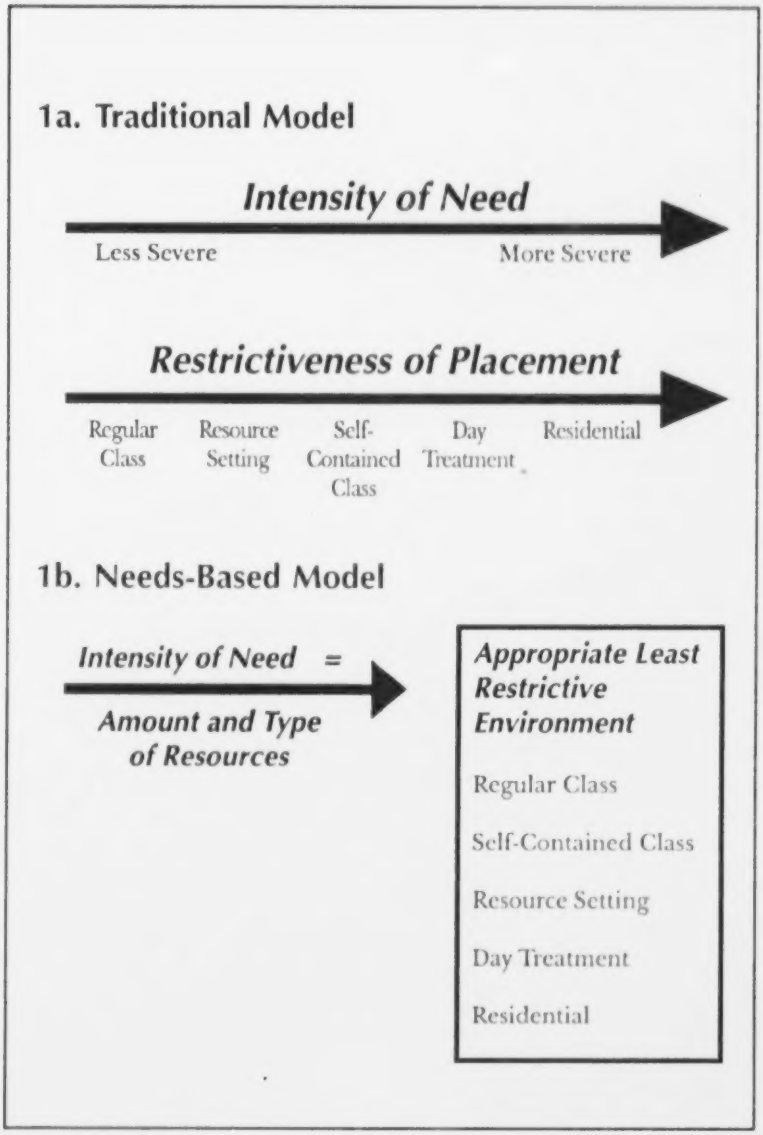
By emphasizing a wraparound planning model, individualized care programs have been able to successfully serve a greater proportion of students with E/BD in the community. Among the most extensive and widely known of these programs is the Alaska Youth Initiative (AYI; VanDenBerg, 1989). Founded in 1985, the program had as its goals returning to the community children and youth placed out of state; limiting further out-of-state placements; and providing individualized case planning, monitoring, program development, and funding for youth and their families. Through such individualized planning, the AYI succeeded in reducing out-of-state placements from a range of 40 to 90 youth in the early 1980s to zero by the fourth year of the program. At the same time, cost savings for the program averaged $32,000 per child. Finally, the wraparound approach has led to improved outcomes for the youth served by the program: Burchard, Burchard, Sewell, and VanDenBerg (1993) detail case studies in which youth who had formerly been institutionalized succeeded in foster care, re-entered regular education classes, completed GEDs, or transitioned to apartment living. VanDenBerg (1989) estimates that 80% of the graduates of the program meet the goal of improved habilitative outcomes.

• Needs-Based Programming at the School Level

While first developed in the field of mental health, concepts associated with systems of individualized care are beginning to be implemented in educational programs. Some school districts, questioning the wisdom of out-of-community placements, are designing programs that stress interagency collaboration and wraparound services to better meet the needs of students with E/BD.

The driving conceptual framework for this approach might be termed a *needs-based model of services* (Cessna & Adams, 1993; Skiba, Polsgrove, & Samraj, 1993). Differences between the traditional and needs-based models of service delivery are presented in Figure 1. In the traditional model (Figure 1a), intensity of children's needs are commonly associated with restrictiveness of placement; a student who cannot succeed with the resources available at a given level of services is typically moved to a more restrictive setting. As Knitzer (1993) notes, however,

FIGURE 1
Differences Between Traditional and Needs-Based Models of Service Delivery



> During the past 10 years, we have learned that intensity does not have to be synonymous with out-of-home placement. Instead, it is possible to create the appropriate level of intensity using natural environments by "wrapping services around" a child and family in his or her own home, classroom, and community. (p. 10)

In a needs-based model of service delivery (Figure 1b), intensity of need at any level of the continuum is associated, not with restrictiveness of placement, but with a corresponding need for increased resources. As the number and severity of student problems increase, so must the resources brought to bear on the problem. Yet a needs-based model makes no assumptions about where those resources will be delivered.

Developing a needs-based-services model fundamentally changes the nature of special education eligibility and placement decisions. In the traditional model, case-conference decision making focuses on first assigning a label, then placing a student in a program specifically intended for students with that label (Grosenick, George, & George, 1991). In contrast, a needs-based approach focuses on three questions:

1. What are the needs of this student?
2. What resources can be brought to bear on meeting those needs?
3. How can those resources be brought to the student?

A needs-based model of services encourages creativity in using resources to design an individualized least restrictive environment (LRE) that meets the needs of each student. Before moving a child to a more restrictive placement, the team first considers the provision of additional resources—consultation, aides, improved behavior management, even parents or community volunteers—to meet the child's needs in the current environment. These resources can be provided in any setting and can enable the planning team to tailor a least restrictive environment for the individual student, based on that student's unique needs.

In part as a result of funding for systems-change grants from the Office of Special Education Programs, a number of school districts across the country have begun to use the concepts of the system of care and individualized care to develop needs-based services. Project WRAP, developed by the LaGrange (Illinois) Area Department of Special Education, has used a "parent-driven" approach to designing interagency, community-based systems (Eber, 1995). The approach has also been expanded to include a wraparound approach to school inclusion. In New Hampshire, Project DESTINY has coordinated ongoing training in three school districts on topics such as social skills training, crisis intervention, col-

laborative teaming, and engaging parents in positive partnerships (Cheney, 1995). Participating schools also engage in a case-study review of individual student performance and work with parents in parent support groups. Finally, Project CONNECT (Polsgrove, Skiba, Benedict, & Jackson, 1995) has implemented a needs-based model of services in two school districts in Indiana. In addition to community-based and family-based team planning processes, the project has made use of two new positions. The *child services coordinator* fulfills the case manager's functions of case coordination and advocacy, while the *systems change facilitator* works with both the school and other agencies to increase and upgrade the amount and quality of resources available to community and family-based teams.

Components of Individualized Services

Key components in providing individualized service include interagency collaboration, goals and commitment, case management, flexible funding, family-based planning, and evaluation.

The previous chapter described the development of system-of-care and individualized-services approaches to service delivery and described some model programs attempting to implement those approaches. This chapter explores some important components that appear to be critical in developing a system of care.

Interagency Collaboration and Coordination

Interagency coordination and collaboration can take place at a variety of levels, from family-based teams at the local level to state-level, policy-making councils. At any level, however, interagency collaborative efforts share a common belief: that coordination of services across agencies can yield improved outcomes, increased satisfaction, and perhaps even financial savings. Gans and Horton (1975) identified three levels of interagency collaboration: *case-centered*, *program-centered*, and *policy-centered*. The case-centered approach is discussed extensively later in this chapter and in Chapter 5; program-centered and policy-centered collaboration are discussed in the following paragraphs.

• Program-Centered Interagency Collaboration

Program-centered efforts involve the coordination of previously disparate and disjointed programs into a comprehensive system of care. Pappas (1994) identifies two types of program-centered interagency collaboration: (a) family service centers and (b) interagency coordinating councils. Family service centers bring agencies together by providing a single location for multiple services. Kids' Place, in southern Indiana, exemplifies this approach by providing a variety of services in a single centralized location, including the county health department, local physicians, an early intervention program, a day care and preschool enrichment program, special education, Head Start, and child protective services. This arrangement promotes collaboration among agencies and between families and agencies while reducing parents' transportation problems.

A second type of program-centered interagency collaboration is interagency coordinating councils, typically at the local level. For example, the Norfolk (Virginia) Interagency Consortium, the systems level coordinating structure for the Norfolk Youth Network, includes representatives from the departments of human services, social services, the public schools, mental health, juvenile court services, and public health (Lourie, 1992). Agendas cover topics as diverse as policies and procedures, gaps in services, creation of new programs, grant writing, system management, and case review.

• Policy-Centered Interagency Collaboration

A policy-centered approach involves a process in which representatives from agencies and organizations meet to "advise, influence, plan, and/or recommend policy changes that affect the larger system" (Pappas, 1993). Policy-centered collaboration often occurs at the state level, although it can also occur at the community or national levels. An example of a policy-centered collaboration is Kentucky IMPACT's State Interagency Council (Nelson & Pearson, 1991). This council is comprised of state-level representatives from various disciplines, such as education, mental health, health, social services, juvenile justice, human resources, and public advocacy. Periodically, this council evaluates Kentucky IMPACT and makes policy and program recommendations; it also reviews the cases regional or local teams are unable to resolve.

At Which Level Should Collaboration Be Focused?

There is some evidence that, especially in the initial stages, interagency collaboration which focuses on meeting the needs of individual chil-

dren may be more productive than coordination focusing exclusively on policy issues. The Alaska Youth Initiative (AYI) has concentrated on building services by meeting the needs of individual children, thus "changing the system one kid at a time" (Burchard et al., 1993). Program components such as a day-school program, respite care, vocational training, or small group homes, developed initially to meet the needs of one child, may benefit others as well. Some authors suggest that the most functional collaborative agreements occur at the local level regardless of the existence of state-level agreements designed to enforce or encourage local level efforts (Elder & Magrab, 1980; Huntze, 1987).

Yet, the presence of funding or procedural barriers to care coordination at the local level means that some form of policy-centered collaboration at the state level is important. In Vermont, although local interagency teams are responsible for case review and local services, the State Interagency Team is enlisted for problems that cannot be resolved at the local level (Santarcangelo, 1990). Such an approach can help identify and remove some of the systems-level barriers that hinder local cooperative levels. It may well be that some combination of "top-down" and "bottom-up" will prove most effective in developing effective systems of care.

Successful programs also appear to start small, to accrue the benefits of "small wins" (Weick, 1984). It may be tempting to begin developing individualized services by convening an all-inclusive interagency task force so as to address as many needs as possible, but a smaller number of agencies committed to meeting on a regular basis may be as effective, and certainly more feasible. Some of the most effective interagency programs documented thus far are composed of collaborations among only two or three agencies, such as the presence of a mental health counseling counselor in a school (Catron & Weiss, 1994). In interagency coordination, as in architecture, form should follow function: The exact level and structure of collaboration may well be dependent on the needs of the children and families being served.

Goals and Commitment

The core values articulated in the original CASSP vision (Stroul & Friedman, 1986)—community-based, child- and family-centered, and culturally competent—may well be the most important defining feature of the system-of-care model. Programs derived from that model all have as their basis a shared philosophy that includes some or all of the original CASSP goals and values (Stroul et al., 1992). This adherence to a set of shared values may reflect a broader truth identified in the organizational change literature; namely, that effective systems change is driven

by a shared vision of what alternative services should look like (Pava, 1986; Weick, 1984).

The most striking of these values, unconditional care or zero reject, has been central in the development of successful individualized programs. First enunciated in the Kaleidoscope program in Chicago (Dennis & Porter, 1993), this principle has two components (Katz-Leavy et al., 1992). First, in terms of intake, youngsters are not rejected or found ineligible for services, regardless of the severity of their presenting problem. Likewise, the principle of "no punitive discharge" means that no youth once in the program is ejected from services due to challenging or disturbing behaviors. Rather, the program may be dramatically changed in an effort to keep the child in the service.

As adopted by the AYI, the value is expressed by Dowrick (1988) in a way that is both eloquent and challenging:

> Yes, we will take care of these children, no matter what they do. If they try to kill themselves, try to kill each other, if they are sexually promiscuous, destroy things, set fires to buildings, assault one another, or generally drive people up the wall, we will take care of them nonetheless. One person will take that responsibility. ... We won't pass this child around anymore. We will take care of this child. (p. 60)

There can be little doubt that children and youth with emotional/behavioral disorders (E/BD) challenge the limits of the most caring individuals and agencies. The commitment to persevere with these youngsters, however, serves as a bridge between services so that these children do not "fall through the cracks."

Case Management

Case management and case coordination have been identified as critical in developing effective individualized care for students with E/BD (Behar, 1985; Burchard & Clark, 1990; Katz-Leavy et al., 1992). Various terms have been used to describe persons performing this function, including therapeutic case advocate (Knitzer, 1982; Young, 1990), case manager (Behar, 1985), family service facilitator (Eber, 1995), and child services coordinator (Polsgrove et al., 1993). Henceforth, this monograph will use the term *child services coordinator* to describe the case management and advocacy role.

The child services coordinator is based on the idea of the therapeutic case advocate recommended by Knitzer (1982) as a "spokesperson" to

coordinate services and ensure that needed are services delivered in an appropriate and sensitive manner. The child services coordinator is both case manager and advocate for individual children and youth with multiple problems. By identifying and coordinating services for students in danger of institutionalization, the child services coordinator does whatever is necessary to ensure that appropriate services are provided. Young (1990) suggested that such a position could operationalize the CASSP model by fostering an "individualized system of care surrounding each child and family."

An important role for the child services coordinator is to involve the family and child as partners in the process of service delivery. This is done by helping families access needed services, preparing them for meetings, and maintaining contact with them regarding the child's progress (Mason & Young, 1990; Young, 1990). The idea of single point of entry has been seen as crucial in helping families deal with the confusing array of social services including the different procedures and eligibility requirements (Nelson & Pearson, 1991). By monitoring and advocating on behalf of specific children and their families, the child services coordinator provides that single point of contact.

The complexity and diversity of problems faced by children who will be served by a system of care means that, of necessity, the roles and functions of the child services coordinator will be diverse. Blazyk, Crawford, and Wimberley (1987) identified five basic services typically performed by case managers:

- *Intake and assessment*. The goal of intake and assessment is to identify (a) clients in need of intensive service, (b) gaps in current services for those clients, and (c) community resources that might be able to fill those gaps.
- *Planning*. The child services coordinator (CSC) takes a leading role in assisting the family in setting goals and developing an intervention plan. Toward that end, the CSC may inventory local resources, bring the case before the interagency team, and facilitate family-based planning.
- *Linking*. In the process of coordinating services for children and youth with E/BD, contacts and relationships formed with other agency personnel can lay the groundwork for an ongoing system of interagency collaboration.
- *Evaluation*. The child services coordinator monitors implementation of the plan and evaluates the plan's effectiveness for both child and family.

- *Advocacy*. A critical aspect of the role is advocating for families and youth with E/BD, on both a case- and class-specific basis (Knitzer, 1984). By attempting to ensure that individual children and their families receive all public benefits for which they are entitled, the child services coordinator is also in a unique situation to identify service gaps and to advocate for change at a systems level.

Flexible Funding

The ability to deliver community-based wraparound services is based, in large measure, on the availability of flexible funds to support such services. Rather than being tied to specific money devoted to categorical placement, individualized care relies upon flexible funds that follow the child (Burchard & Clarke, 1990). In such programs, funds that might otherwise be spent on out-of-community placements are spent on services that are wrapped around the child and family in the community.

Dollard, Evans, Lubrecht, and Schaeffer (1994) identify two levels of flexible funding. First, flexible funds can be generated at the *macro* level, through blending funding streams from several human service agencies into a single fund, often referred to as *pooled funding*. At a more *micro* level, flexible funding refers to the establishment of procedures guaranteeing noncategorical funds—money not tied to a specific system or program—are available to meet the individual needs of children and family, rather than paying for specific service options.

Key to the notion of flexible funding is the concept that "funding follows the child." In programs such as the AYI, funds that would have been spent on out-of-state services are redirected toward providing a variety of community-based wraparound services (Burchard et al., 1993). The savings engendered by moving from residential or hospital-based treatment to local wraparound service can be substantial; the state of Indiana, for instance, estimates that private residential costs average about $94,000, while costs for community-based services used as part of a wraparound plan average $35,000 (Hugo & Cass, 1994). These savings can be used to support a variety of community-based services, including behavioral consultation, individual counseling, respite care, family-based services, and behavior management.

At the local level, planning for resources to support needs-based services requires some creativity. Vermont's Project WRAPAROUND, for example, supports individualized care in part through a creative use of Medicaid waivers known as the Home and Community Care Waiver

(Katz-Leavy et al., 1992). In the District of Columbia, social service agencies use an approach called "sizing components of care" to estimate the needs and financial resources for each component of the system of care (Pires, 1990).

Family-Based Planning

Stroul et al. (1992) note that successful system-of-care programs involve parents in the process of developing individualized service plans. If parents are to be the active partners needed for developing effective services, agency personnel must adopt a family-centered approach that enables and empowers families (Dunst, Trivette, & Deal, 1988). Principles suggested by McGonigel, Kaufman, and Johnson (1991) for the development of individualized family service plans provide a sound framework for guiding the teams that will develop the plan:

- Each family has its own structure, roles, values, beliefs and coping styles. Respect for and acceptance of this diversity is the foundation of family-centered intervention.
- Intervention strategies must honor the racial, ethnic, cultural, and socioeconomic diversity of families.
- Family/professional collaboration and partnership are keys to successful intervention.
- Intervention services should be flexible, accessible, and responsive to family-identified needs.
- No one agency or discipline can met the diverse and complex needs of families with children with special needs. A team approach to planning and implementation is necessary.
- Families should have access to services that are provided in as normal an environment as possible and in a manner that promotes integration within the community as much as possible. (McGonigel et al., 1991, p. 9)

The AYI provides an excellent example of the process through which interagency collaboration works for individual children and youth (Katz-Leavy et al., 1992; VanDenBerg, 1989). Determinations of eligibility are made by the state-level *interdepartmental team*. Each identified youth is then assigned to a local *education and treatment team* made up of all persons, especially family members, who are influential in the child's life. This team assesses the youngster's basic needs in eight life domains (residential, family, social/recreational, psychological, educational, vocational, medical, and legal) and generates a list of possible solutions, regardless of whether those services are currently available. Next, the team examines each proposed component from a standpoint of fea-

sibility, gradually finding alternatives that appear workable. The local team sends this plan to the interdepartmental team, which considers cost, creativity, and legal considerations. If the plan is accepted by the interdepartmental team, the local education and treatment team is responsible for implementing and ongoing monitoring of the plan.

A family-based planning process must respect the strengths of families. Too often, parents are either shut out of treatment planning or regarded as part of the problem (Eber, 1995). In a true collaborative process, parents are integral members of the planning team, and their strengths and expertise are viewed as an important resource in developing the intervention plan.

Evaluation

Whatever their promise, systems of individualized care are still experimental. Also, in an era of increasing demands for accountability, a strong evaluation component is important to ensure that all funds are used efficiently (Jordan & Hernandez, 1990; Katz-Leavy et al, 1992).

First, all dollars spent on wraparound services must be strictly accounted for. Successful programs such as the AYI require a "paper trail" to document how flexible funds are spent (Katz-Leavy et al., 1992). Often these data provide a solid argument for the continuation of such services, because community-based alternatives are often far less expensive than out-of-community residential treatment.

Second, programs should be evaluated to document their effectiveness in providing improved services to children with E/BD and their families. Evaluation should be viewed as an integral part of program planning. As new program options emerge for individual children or at the system level, the team should ask themselves, "What do we hope will be the outcome of this plan or program, and how will we know if we have achieved that goal?" Evaluation can focus on either the *process* or the *outcome* of collaboration.

• Process Evaluation

Process evaluation refers to an analysis of the steps involved in delivering services (Mason & Young, 1990). Teachers, administrators, parents, and agency personnel may provide valuable information concerning how well the process of collaboration worked. Specific targets for process evaluation might include characteristics of cases not accepted, quality of solutions proposed by interagency collaboration, types of agencies

involved and amount of shared information, effectiveness and accessibility of the child services coordinator, and the extent to which the treatment plan was carried out as planned (Mason & Young, 1990).

Another important process indicator is the degree of parental involvement and satisfaction with the process. Assessing such issues as the degree to which parents feel welcome to participate is critical to the adherence to the CASSP principle of family-focused services.

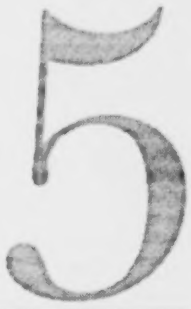
• Outcome Evaluation

A variety of outcome variables should be considered when evaluating the effectiveness of interagency collaboration. *Maintenance in the community* can be assessed by comparing data on students served in the home community with out-of-district and out-of-state placements. Other indices include the success of transition to the home community and the recidivism of those returned to their home communities.

School-based measures may include academic progress, suspension and expulsion, school attendance, school dropout, critical incidents (e.g., school violence, suicide), behavior rating scales, and movement through the continuum. *Community-based measures* focus on the degree of use and contact with agencies and community programs and may include the number and type of services provided per child, average time to appropriate placement, number of students served in inpatient versus outpatient settings, number of children entering juvenile detention, and number of children who received or failed to receive services.

Finally, *cost effectiveness* may be assessed by comparing the average cost of services provided under the old and new models of services. Demonstrating both cost avoidance and improved treatment outcomes has been found to be vital to maintaining support from policy makers (Jordan & Hernandez, 1990).

Developing a Local System of Care



Overcoming barriers to interagency collaboration demands support for the coordinator role and an interagency planning process that focuses on the needs of children and families.

Impetus for developing community-based systems of care has come primarily from the field of mental health (Stroul & Friedman, 1986). Yet schools are most often the primary focal point of services to children. If the complex needs of youngsters with emotional/behavioral disorders (E/BD) are to be met successfully, schools must become full partners in developing an integrated system of services.

The following narrative describes key strategies and considerations important in developing a system of care in a local district. These suggested steps are not intended to be comprehensive; rather they are representative of the activities the team will pursue in developing an individualized system of care. Steps include support for the child services coordinator role, identification of participating agencies, organizational issues, needs assessment, target population, mission statement, confidentiality, and the planning process itself. Prior to that discussion, however, it is important to consider some important barriers that need to be addressed in establishing a system of care.

Barriers to Interagency Collaboration

Despite general agreement that interagency collaboration is desirable, it is often very difficult to orchestrate or sustain (Friesen & Koroloff,

1990). Some studies have demonstrated impressive failures when attempting to intervene by means of interagency collaboration (Byles, 1985). At the very least, false starts in the name of interagency cooperation mean that the collaboration model must be chosen with care to maximize the benefits.

Weiss (1981) observed that "the activity of coordination is itself fraught with peril" (p. 24) and identified four major obstacles to integrating services. First, *conceptual conflicts* over the goals of coordinated services include information sharing, resource allocations, and assignment of case responsibilities. Second, *professional resistance* may present a formidable barrier because professionals from different disciplines hold disparate views regarding treatment philosophy and procedures and may view attempts to depart from standard practice as a threat to professional expertise. Third, *bureaucratic constraints* in the form of standard operating procedures, organizational incentives, and supervisory control all diminish motivation for interagency collaboration. Fourth, the *political contexts* in which systems operate can present a considerable hurdle. Attempts at reform can threaten to dislodge patterns of regularity established over years and can spark power struggles over control, priorities, resource allocations, and services goals.

In the face of such obstacles, it is probably advisable to build the system of care gradually over time. More positive results seem to be associated with small-scale, informal projects with a limited target population than efforts at creating sweeping agency changes (Guthrie & Guthrie, 1991; Weiss, 1981). Successful systems appear to focus first on the child and family, and let their experience in improving services for individuals act as their guide in reforming the system.

As noted, one of the most important components in changing the system "one kid at a time" is the presence of an individual who can oversee the process and act as an advocate for child and family. Thus the following section focuses on that person.

1. Establishing the Role of the Child Services Coordinator

As noted, the literature on needs-based services indicates that some form of case management is a central feature of successful models (Behar, 1985; Boyd, 1994; Young, 1990). Knitzer et al. (1990) view these positions as "important in 'gluing' together a package of individualized services. ... They can be important in helping frame service plans, moni-

toring their implementation, intervening as system broker, and, in general, ensuring that specific goals are met" (p. 74).

Yet, school-based consultants such as child services coordinators cannot function effectively without various types of administrative support (Polsgrove & McNeil, 1989). Prerequisites for an effective child services coordinator role include flexibility, training, administrative support, a reasonable caseload, and clear professional responsibilities.

• Flexible Role Definition

Moving from urban to suburban to rural systems, both the needs of children and the structure of social services may change. For example, Project Connect (Polsgrove et al., 1993) involves both a rural community with only a few local agencies available for service provision and a large urban system with a multitude of agencies. As the number of agencies increases, the availability of service options increases, yet so does the complexity involved in developing interagency networks.

To meet these divergent needs, the child services coordinator (CSC) must have the latitude to structure the responsibilities of the position in response to local demands and the flexibility to change as needs evolve. The CSC also must have some authority to enter into cooperative agreements with other agencies and to allocate appropriate district resources required in constructing child service plans.

• Training

Evaluations of individualized care approaches have identified training as one of the most difficult challenges in implementing new models of service (Burchard & Clarke, 1990; VanDenBerg, 1989). The CSC position requires a professional with extensive formal training in the areas of E/BD and consultation strategies and direct experience in working with this population of children. It is also ideal for CSCs to have a transdisciplinary background and be familiar with the roles and objectives of various child and family services agencies.

• Administrative Support

In order for any school-based consultant, such as a CSC, to function effectively, clear role definition and adequate administrative support are critical (Polsgrove & McNeil, 1989). Types of administrative support that will make the position more effective include travel funds, office space, manageable caseloads, and recognized status. As with any school

consultant, the role and functions of the CSC should be carefully delineated and circulated to building administrators and teachers with whom the CSC will be collaborating (Conoley & Conoley, 1992; Dettmer, Thurston, & Dyck, 1993).

- **Caseload**

Perhaps the most important element of support from administrators involves policies that keep caseloads at a reasonable level; even the best programs can be destroyed by inundating personnel with case assignments. When cases require intensive services such as those involved in family preservation, case management, or advocacy, a manageable caseload is essential. Adequate time also needs to be allotted for development of working relationships, agency councils, and local site coordination and training. A caseload of no more than 10 to 12 cases has been recommended as optimal (Stroul et al., 1992).

- **Clear Professional Responsibilities**

For an individualized system of care to operate efficiently, the CSC role must be regarded as a permanent professional position with the specific responsibilities for system development related to children with E/BD. This individual must not be considered as simply another related services staff worker, IEP conference coordinator, or special deputy who handles emergencies for a district. In addition the CSC must be accorded appropriate authority in making placement decisions, supervising staff, and brokering district resources with other agencies.

Depending upon available resources, it may not be feasible to create a separate position for the role of CSC. It may be that the position will be filled by a qualified, highly trained professional, such as a school psychologist, teacher of students with E/BD, social worker, or counselor. It is critical, however, that any personnel given the responsibilities of CSC also be allowed time to carry these out. A commitment to change may not require large amounts of new resources; it does, however, entail a commitment not to make heroic individuals carry the entire weight of change on their backs.

2. Identifying Participating Agencies

Once the CSC position is established, that individual can begin outreach efforts to bring other agencies together. The decision concerning which agency representatives and other stakeholders should be involved in initial efforts to improve services may be based on several factors: the

needs of the target population, key agencies required to effectively meet these needs, history of working relationships of various agencies, and the particular outcome desired. Planners might consider two alternative approaches.

The first approach involves convening a broad coalition of agency representatives in a series of planning meetings as a means of creating a general climate for change. Community efforts such as the Norfolk Youth Network (Lourie, 1992) have successfully used this approach to build community cooperation. Such an approach has the advantage of allowing those agencies that wish to be involved in a systems restructuring effort to voice their concerns and to connect with others who share a commitment to participating in this process. Such efforts appear to be most successful in the face of a legislative or court mandate to improve services (Behar, 1985).

If a large-scale effort is not feasible, or if there has been a negative history of collaboration, smaller scale efforts may be more appropriate. Knitzer and Yelton (1990) recommend starting with informal meetings and using the "take-your child-welfare-mental-health-counterpart-to-lunch" approach (p. 33). Small-scale efforts simplify the initial planning stage by linking key agency representatives who are comfortable with each other and motivated to change their relationship. Once they have "the ball rolling," other stakeholders might then be invited to contribute to the planning process either through meetings or by reacting to drafts of a working plan. One of the most successful programs, the Ventura Planning Model, came into being through the efforts of a special educator who organized a series of brown bag lunches among agency heads (Goldman, 1992).

3. Organizational Issues

Once major social services agencies in a community are identified, the initial step is to schedule an organizational meeting to explore common ground for interagency cooperation.

• Setting a Schedule and Agenda

Few professionals look forward to meetings, especially those that are poorly planned and lack substance. It is important, therefore, that an organizational meeting be a significant event, one that sets the tone for subsequent meetings. Without a clear agenda, interagency collaboration meetings can collapse into what Guthie and Guthrie (1991) term NATO (No Action, Talk Only) gripe sessions. To set the tone for subse-

quent events, however, we recommend developing an agenda for the first meeting and distributing it prior to the meeting; setting and adhering to strict time limits; and conducting the meeting in a crisp, business-like manner. For example, the Kentucky Impact project has developed a standard meeting format called the "High Performance Service Team Meeting" (Nelson & Pearson, 1991). That meeting sets clear timelines for every task to be undertaken, from introductions to case presentations to goal setting to developing the interagency service plan. As a result, team members come to trust that their time will be spent productively.

• Information Sharing

One major barrier to successful interagency collaboration is often a basic lack of information about other agencies and their operations. Thus, an initial meeting might be best devoted to "getting to know" each stakeholder's agencies. To facilitate this effort, the CSC might ask each agency representative to prepare a brief on their agency for distribution to other committee members. For the initial meeting this might involve a simple summary of agency functions, organizational structure, and an overview of various programs. This information also could be used as a resource guide to acquaint new committee members with the functions and resources of participating agencies.

• Ongoing Activities of the Interagency Council

Regular meetings are essential for maintaining continuity and creating a sense of momentum for developing services (Hooper-Briar & Lawson, 1994). An important task for early organizational meetings is to clarify the role of the interagency team and the structure of further meetings. There appear to be two important responsibilities for the community interagency team. First, the team has responsibility for overall improvement of services. This may include ongoing education of team members regarding services provided by other agencies, discussion of barriers to service provision, community needs assessment, and development of new options to meet identified community needs. Second, the community-based interagency coordinating team is responsible for authorizing, monitoring, and evaluating child service plans. Effective community teams appear to structure their meetings to allow for completing both activities (Stroul, 1993). Thus, the first half of the meeting might be devoted to organizational issues, while the second half might be reserved for a consideration of individual cases needing attention.

After the interagency committee has established the need for interagency collaboration and decided on a meeting structure, the council can proceed toward greater collaboration. This process is described in greater detail in various sources (e.g., Hooper-Briar & Lawson, 1994; Nelson & Pearson, 1991). The Regional Resource Center Task Force on Interagency Collaboration (1979) developed a flowchart summarizing nine major steps a local interagency committee might use to guide their efforts (see Table 2). Some important tasks that need to be accomplished by the team are described in the following sections.

4. Needs Assessment

To improve services, agency representatives require information on district needs and the steps that might be taken to restructure the existing service delivery system. Friedman (1988) suggests that the purpose of a needs assessment is to provide information useful in developing an effective model of services. This information includes (a) a clear set of values and principles, (b) an analysis of the characteristics of the state or community, and (c) an examination of the advantages and disadvantages of various models.

A number of resources are available to assist in the needs assessment process. An inventory developed by Melaville and Blank (1991) offers a series of important questions to encourage reflection and discussion on the need for change; these questions are reprinted in Table 3. Stroul and Friedman (1986) provide a comprehensive model for assessment of the presence of the system of care. Worksheets in that resource assess the extent to which the eight components of the system of care (mental health services, social services, educational services, health services, substance abuse services, vocational services, recreational services and operational services) are available and effective in the community. Finally, an excellent self-study guide for community collaboration teams is available from the Georgetown University Child Development Center (Bronheim, Cohen, & Magrab, 1985).

A needs assessment must itself be responsive to local needs and resources. It may be less important that a needs assessment be comprehensive than that it answer important questions in a timely fashion. Finally, needs assessment need not be viewed as a prerequisite that must be completed before any activity can be initiated. Kuh, Hutson, Orbaugh, and Byers (1979) point out that needs assessment is an ongoing process that continues to provide feedback, even after new activities and structures have been put in place.

TABLE 2
A Process Outline for Interagency Planning

Establishing the Need	*Determine* needs and rationale for initiation of interprogram collaboration project. 1.0	*Define* service delivery population of interest. 2.0
Establishing the Database	*Identify* agencies and programs serving or authorized to serve the target population(s) and contact agency administrator 3.0	*Define* current program policies and services and responsibilities of identified programs. 4.0
Identifying the Planning Targets	*Compare* local programs and procedures across agencies to identify gaps, overlaps, constraints, and other linkages 5.0	*Identify* local policy and procedures wherein modifications would enable satisfaction of need and rational for collaboration and *specify* the needed modifications. 6.0
Establishing Interagency Provisions	*Determine* which modifications can be made on the local level and incorporate these modifications in a local interprogram agreement. 7.0	
Ensuring Collaboration in Service Delivery	*Enable* implementation of interprogram modifications. 8.0	*Implement* local evaluation functions. 9.0

Note. From Guidelines for Preparing Interagency Agreements. *Interagency Collaboration on Full Services for Handicapped Children and Youth, Volume 2: A Guide to Local Implementation*, 1979, by the Regional Resource Center Task Force on Interagency Collaboration, Department of Health, Education, and Welfare. Reprinted with permission.

TABLE 3
Assessing the Need for Interagency Collaboration

How are we doing on our own?

1. Are the lives of the children, youth, and families we serve improving. If not, why not?
2. Have we reassessed our mission recently in light of the overlapping economic, education, health, employment and social services needs of our clients?
3. Are services to clients well-integrated within out own agency?
   a. Do staff working with the same clients communicate frequently?
   b. Do staff and clients work together to set personal and family goals?
   c. Does our agency measure the impact of its services on the lives of children and families or do we simply tabulate the number of services we provide?
   d. Do we offer preventive supports and services to help our clients avoid more serious problems?
   e. Are our services organized in response to client needs or are the kinds of services we offer constrained by the limitations of available funding and administrative rules?
4. How well are we connected with other agencies offering services which our clients need?
   a. Do our line workers have effective working relationships with their counterparts in other agencies?
   b. When our clients are referred elsewhere for services are we kept informed of their progress and changing needs?

Do we need to change?

1. How effective will we be in ten years if the needs of our client population continue to increase and we continue to do "business as usual"?
2. What resource limitations do we face in bringing more comprehensive services to our clients?
3. How might closer relationships with other agencies help us improve outcomes for the families we serve?

How ready are we to engage in interagency partnerships?

1. Do the agencies serving children and families in our neighborhood, our school community, our city, our county, have a common vision of what they are trying to accomplish?
2. What is the history of cooperation and collaboration in our neighborhood, community, city/county? What lessons can we learn from past experience (or lack of it?)

Continued

TABLE 3, *Continued*

3. Do we have close working relationships with the directors of other agencies that deliver services to the same clients? What do we know about other agency's current needs and priorities that might encourage them to discuss common problems and potential solutions on behalf of our clients?
4. Who are the leaders from outside the direct service community who are interested in the well-being of the community and who might take a leadership role in a collaborative effort or assist with the expansion and improvement of ongoing activities?
5. What are we willing to pay in terms of tangible resources and loss of unilateral control to formulate common goals with other agencies and to better serve our shared clients?

Note. From *What it takes: Structuring interagency partnerships to connect children and families with comprehensive services* (p. 38) by A.I. Melaville & M. J. Blank, 1991. Washington, DC: Education and Human Services Consortium.

5. Defining the Target Population

Reviews of eligibility criteria across programs (Katz-Leavy et al., 1992) indicate a number of widely used criteria. These include children whose emotional or behavioral problems are so severe as to cause functional impairment, placement or risk of placement in an out-of-community facility, and involvement with at least two agencies. Many programs also require a DSM diagnosis, although the reliability and validity of such diagnosis has been questioned (Burchard et al., 1993).

While target population definitions vary widely depending on the local needs of the community (Epstein et al., 1993), most comprehensive-system-of-services models were developed to bring children and youth placed out of state back into their home community. Targeting "deep-end" children may be financially advantageous, in that money that might otherwise be used for out-of-state placements can be reinvested in local services. The Ventura Planning Model, for instance, targets those children who display behavior or emotional problems so severe that they face a substantial risk of removal from their homes or of becoming a public legal or fiscal responsibility (Jordan & Hernandez, 1990).

Several programs reported in the literature have targeted a wider range of children. The Gateway project, in Richland County, Ohio, targets a

population broadly defined as "children with multiple needs and their families" (Stroul, 1992). The broad definition is purposely intended to reduce categorical thinking and to promote shared ownership of the problems of this population. Other programs have found that their population definition has expanded over time. The Alaska Youth Initiative (VanDenBerg, 1989) reported that success with a more limited population (i.e., those served out of state) allowed them to consider serving a broader range of children (i.e., those *at risk* for out-of-state placement).

There are three important considerations in defining a target population. First, consider the unique needs of children and families in the local area. In defining its target population, the Norfolk Youth Network considered Norfolk's transient military population as well as the impact of poverty and drug abuse in the inner city (Arnold, Moore, & Moran, 1991). Second, keep the initial discussion of target population separate from a consideration of available services. Definitions not limited to currently available services encourage creativity in designing individualized systems of care that meet the needs of children and families. Finally, start small (Guthrie & Guthrie, 1991). While it is not uncommon for a system of care approach to expand its mandate as agencies learn to cooperate, it is important to first learn how the process can best operate on a few successful cases.

6. Developing a Mission Statement

As noted, successful systems-of-care approaches have been characterized by the presence of a strong guiding philosophy. As a step toward creating focus, interagency planners should spend time early in the process developing a shared vision of services for students with E/BD. The values statement of a system of care (Stroul & Friedman, 1986; see Table 1) may provide a helpful stimulus, as may vision statements of other successful projects such as Ventura (Jordan & Hernandez, 1990). Initially, the team may wish to keep its consideration of mission and values independent of available resources; at some point, however, it will be necessary to test the feasibility of the mission statement in light of resources. The result of this dialogue will be a mission statement outlining the team's general philosophy regarding how it will approach the issue of providing services to children with E/BD and their families.

7. Confidentiality

Regulations such as the Family Educational Rights and Privacy Act are essential in protecting the privacy rights of individuals. Yet, rules that

govern the sharing and release of records within different systems often operate in opposition to one another. The result is often frustration and stalemate, as schools are denied access to mental health, medical, or corrections information they need and vice versa.

Yet there may be fairly simple procedures that can be used to address problems of confidentiality. Because most confidentiality regulations are designed to protect the rights of parents and their children, many confidentiality obstacles can be sidestepped by involving parents in the process and gaining their permission for a generic record release that covers all agencies involved in the interagency team (Ross, 1992). A full discussion concerning confidentiality among the participating agencies is also important. Such a discussion can focus on clarifying reasons for sharing information, identifying and addressing legal and ethical concerns held by each agency, and developing a common release form (Joining Forces et al., 1990).

8. Designing a Responsive Planning Process

One of the most important tasks in integrating services is deciding on a service delivery model. While making contact with other service providers is an important first step, regular meetings will probably not, in and of themselves, result in significant change. Without a clear focus on meeting the needs of children and families, the multitude of barriers to collaboration may doom interagency efforts to failure (Weiss, 1981). Thus it is important that planners become aware of and select a model of interagency collaboration to guide their efforts.

The literature on interagency collaboration (Friedman, 1988; Guthrie & Guthrie, 1991; Katz-Leavy et al., 1992) has identified three approaches that appear to be most typically used in guiding reform, two of which have been described in some detail in this monograph. The system-of-care approach outlined in Chapter 3 was first described by Stroul and Friedman (1986); its primary focus is on pulling together key personnel from various agencies (Friedman, 1988). The core values of child-centered and family-focused planning, community-based service, and culturally competence are critical to implementation of the model. The second approach, *individualized care* (Burchard & Clarke, 1990), also described in Chapter 3, evolved from the system-of-care model and emphasizes wraparound services, flexible funding, and unconditional care. The third approach used to bring services together might be termed *co-location of services*. In this model, a number of services, ranging from mental health to child welfare to probation, have offices in one central location, most typically the school. A less extensive variant involves

placing one agency, such as mental health counseling, in a school setting (Catron & Weiss, 1994). Friedman (1988) recommends to those considering service delivery changes that they consult with others who have engaged in the process of integrating services, and perhaps even arrange site visits, to gain a better understanding of the components and possible pitfalls of each model.

Each type of services integration involves its own challenges. The extensive cooperation necessary to develop a *system of care* requires a collaborative approach to decision making that is foreign to most agency representatives. Knowledge of techniques of negotiation and conflict resolution are therefore important in preventing conflict and process breakdown among the participants. Fisher, Ury, and Patton (1991) offer a general strategy which agency representatives can employ for dealing with disagreements that might arise in attempting to meld services. This approach, an outgrowth of an ongoing research project on legal mediation and international conflict resolution, involves the use of four principles: (a) separating the individuals in conflict and their related emotions from the problem under consideration, (b) focusing on interests of the individuals involved in the dispute rather than the position they have taken, (c) identifying options that will meet everyone's interests, and (d) using objective rather than subjective criteria for determining the best choice of solutions to a conflict. These principles, when accompanied by interpersonal tactics such as avoidance of accusations and argumentation, relationship building, perspective taking, active listening, clear communication, and participatory problem solving provide a means of resolving conflicts amicably and productively.

There may also be a measure of unfamiliarity and discomfort in bringing teachers, parents, and agency personnel together for problem solving and planning. Thus, wraparound approaches often rely on techniques of individualized planning that are used to "manage the adults." Such techniques allow family, school, and agency representatives on the planning team to work together to brainstorm, prioritize, and assign responsibility for strategies to meet the needs of the child and family.

Co-location of services may be among the most potent of service system reforms, because it places a variety of agencies in one location; yet the issues involved in gaining the necessary commitment of resources in this approach can be complex. A more formal needs assessment process may be helpful to estimate the extent of need and cost of the services (Pires, 1990). An important aid in such efforts may be an interagency cooperative agreement. This document might be framed as a "memorandum of understanding" outlining basic responsibilities and operat-

ing procedures to be assigned to various agencies. Further resources on written interagency cooperative agreements and sample agreements can be found in Elder (1980) and Nelson and Pearson (1991).

Whatever the model chosen, it is important to maintain a focus on the values and principles that undergird successful integrated services approaches. Maintaining an emphasis on values, such as child- and family-focused, reminds participants that they are not simply collaborating for collaboration's sake. Rather the ultimate goal of any restructuring of services is to make services more effective and efficient for children with E/BD and their families.

Conclusions

Children with emotional/behavioral disorders (E/BD) and their families currently face difficulties of crisis proportion, a crisis reflected in the social service system. For many families, changes in society and the economy make day-to-day existence and child rearing difficult endeavors. The increasing incidence of underemployment, poverty, neglect, conflict, and physical, sexual, and psychological abuse has created challenges that go well beyond the capabilities of the current system of social services.

In the face of such challenges, local and state agencies and institutions across the country are reexamining their systems of services and considering alternative models to integrate services. The system-of-care model (Stroul & Friedman, 1986) brings agencies together around a shared set of community-based and family-centered values. In the years since Knitzer (1982) identified glaring gaps in services for children with emotional disturbance, model programs have sprung up around the country (Boyd, 1994), many of which have shown real promise in addressing those gaps (Davis, Yelton, & Katz-Leavy, 1993; Schlenger, Etheridge, Hansen, & Fairbank, 1990; Stroul, 1993). Individualized care approaches (Burchard & Clarke, 1990) have taken these concepts one step further, emphasizing needs-based planning, case management, wraparound services, flexible funding, and unconditional care. Successful individualized care programs, such as the Alaska Youth Initiative, have reduced their out-of-state residential placements to zero while generating significant cost savings (Burchard et al., 1993). Although these approaches grew out of the field of mental health, schools are now beginning to take a lead role in integrating services. Needs-based approaches at the school level (Cheney, 1995; Eber, 1995; Polsgrove et al., 1993) have begun to take the principles of individualized care and apply them in school settings.

The philosophies and strategies presented here—interagency collaboration, unconditional care, child services coordinators, flexible funding, and family-centered planning—are all promising tools with which

to reshape systems of service. Although these approaches have yielded encouraging results in programs across the country, it is important to remember that such programs are still under development. The success of any particular program hinges in large part on the readiness of the local community to engage in and support these strategies.

Successful needs-based programs often share a common approach to restructuring services that involves both a statewide initiative and a "grass-roots" approach. To date, many of the most successful programs have come from the field of mental health. However, as the public school stands as *the* central agency in the lives of children and youth and, unlike mental health agencies, receives funded mandates to provide services, it appears most logical that local districts take the lead in organizing interagency efforts. Thus an emerging trend involves organizing school-*linked* approaches in which a district becomes the hub of a services network, as well as school-*based* models where direct services are provided in the school building (Hooper-Briar & Lawson, 1994).

The strategies and principles presented herein need not be adopted wholesale in order to be effective. Many of the principles of needs-based services might be adapted by a district to improve its services at the building level. Principles and procedures such as wraparound and flexible funding may provide new and innovative ways to conceptualize programming for inclusion (Skiba, 1994). The transition toward a needs-based model of service delivery might best be viewed more as a journey than a destination that needs to be reached by a given time. The experience of successful programs suggests several guideposts for that journey:

- *Start small.* In an effort to promote comprehensive systems change, planners often wish to address the "whole problem." Yet the complexity of understanding and addressing the entirety of the system of services for children with E/BD is overwhelming and may only lead to frustration and paralysis. In contrast, small successes on trial cases can reinforce participants and make taking the next step toward effective service integration more likely (Weick, 1985).
- *Focus on child and family needs.* Perhaps the surest route to discouragement in interagency collaborative efforts is a series of unfocused and unproductive meetings. It is probably no accident that the most highly successful programs have been those which have emphasized the value of unconditional care. Focusing on the needs of specific children and families acts as a continual reminder of the reason why alternative programs are designed and reinforces participants for "making a difference."

- *Select a qualified child services coordinator.* The position of the case manager has been identified as crucial in designing effective individualized care (Behar, 1985; Boyd, 1994). In this book the term child services coordinator is used, and that position's critical roles and resources have been outlined. The important point is that, regardless of how the position is structured, this person has to have the role flexibility, authority, time, and administrative support necessary to carry out the complex responsibilities of the position.
- *Use existing structures.* Although many of the terms presented as part of a needs-based model may be new to school personnel, the concepts of individualization and child-focused services are already well established in the Individuals with Disabilities Education Act. Making use of the structures and processes already in place in special and regular education will make acceptance and institutionalization of interagency collaboration more likely. Family-based planning teams might, for instance, be folded into the IEP planning process.
- *Be persistent.* Because of the myriad barriers to effective interagency cooperation, it may be wisest to expect some difficulties as one moves toward integrating services. With careful evaluation data and a continual focus on the needs of children and families, however, such experiences can become useful data for continual refinement of a system of care.
- *Evaluate, evaluate, evaluate.* It is impossible to overstate the importance of evaluation data in the process of restructuring services. New approaches to service integration are promising but still under development. Sound evaluation data are a key component in the responsible development of new approaches to helping children with E/BD and their families. In fiscally conservative times, such data may also be critical in securing the support of policy makers. As Starfield (1988) notes, "policy makers often need that extra little bit of help to do what they really want to do, but can't justify without the help of researchers and evaluators" (p. 85).

  Evaluation need not be seen as an intrusive process external to practice; rather, it might be better viewed as a series of questions concerning the outcomes of services. How does a monthly planning meeting among agency representatives affect the quality of services provided? Does the assignment of a child services coordinator to monitor case activities yield better outcomes for children with E/BD and their families? Is there greater parent satisfaction if family-friendly and culturally competent services are provided? The answers to such questions will enable continual progress toward the goal of a locally coordinated system of care.

In conclusion, throughout this consideration of integrated services, we have been struck by a glaring paradox. Education, like most social services, is populated by caring individuals who enter the field out of a desire to help children. Yet the structure, constraints, and procedures of the current system of services often act to limit the ability of professionals to translate that concern into action. The ultimate challenge for new models of service delivery may be for those caring, highly trained individuals to reshape the agencies of which they are a part, so that those social structures become a system of care that can better meet the needs of children with E/BD.

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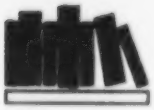

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